Staff Health Screening Form

Date: _____ Child Care Program: _____

Please answer the following questions to the best of your ability:

Staff's Name	Do you have any symptoms of COVID-19 listed below? Y or N	Have you or anyone in the household traveled outside of ME, NH, or VT in the past month? Y or N	Have you come into contact with anyone who has tested positive with COVID-19? Y or N	Is anyone in your household experiencing signs of illness? Y or N	Staff's temperature	Staff signature (agreeing to the information)	2nd Staff person's initials

Symptoms of COVID-19: Cough, Shortness of breath or difficulty breathing, Fever (body temperature above 100.4 degrees Fahrenheit), Chills, Repeated shaking with chills, Muscle pain, Headache, Sore throat, or New loss of taste or smell